Medical Residency Programs:
A Report of the Florida Board of Governors

Florida Board of Governors
Office of Academic and Student Affairs

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Introduction

When the Board of Governors approved two new medical schools for the State University System (SUS) on March 23, 2006, it did so by means of a resolution that reflected the need to address all facets of medical education if Florida was to make progress in providing quality healthcare to its citizens. Accordingly, the Board's resolution contained these sections pertaining to medical residency programs:

> WHEREAS, the Board finds, along with virtually all stakeholders, that creating more medical residencies is a first and immediate priority for Florida's healthcare system, and therefore urges the Florida Legislature to work with the Board, the existing medical schools, and all other appropriate bodies and constituents to increase and fund an appropriate number of additional high-quality residencies affiliated with those medical schools through existing or new programs in order to attract and retain more Florida medical school graduates, including access to those from underserved populations; and
>
> WHEREAS, the Board finds that institutions providing residency programs must be encouraged to periodically review their residency programs, making adjustments to ensure that residencies are in specialties that meet the needs of the population and that attract and retain new physicians, including access to those from underserved populations…

The purpose of this paper is to provide the Board of Governors with information relative to the status of medical residency programs nationally and in Florida, and to make recommendations for future Board action.

Report Limitations

Three caveats must be stated. First, reporting by even the same agency but in different places is sometimes inconsistent, as some numbers are updated in "real time" and others are reported periodically.

Secondly, critical information with regard to the specifics on Florida's physician workforce and, accordingly, Florida's residency needs by specialties is not yet available. The Florida Department of Health has done a commendable job of beginning to gather this information, but there is more work to do.

And finally, the report will not do justice to Nova Southeastern University's College of Osteopathic Medicine. Two types of physicians are licensed to

practice medicine in all 50 states: the Doctor of Medicine (M.D.) and the Doctor of Osteopathic Medicine (D.O.). Nova Southeastern University College of Osteopathic Medicine, a critical component of Florida's health care system, is accredited by the American Osteopathic Association (AOA).

Residency Programs: A Definition

A *residency* is a post medical school experience varying in length from three to seven years depending on the specialty area. In the world of medical education, a residency is also referred to as *graduate education* or *graduate medical education* (GME) to distinguish this activity from the medical school experience.

The path to the M.D. begins at the undergraduate college/university level, where students fulfill basic pre-medicine coursework requirements, mostly in the sciences--biology, chemistry, mathematics, and physics. The average medical school applicant then applies to 13 allopathic medical schools. In 2007–2008, more than 42,000 applicants competed for slightly more than 18,000 first-year positions nationally. The medical school experience, called "undergraduate medical education (UGME)", is usually four years, at which point graduates are Medical Doctors (M.D.) or Doctors of Osteopathic Medicine (D.O.). What typically follows is the residency experience.

In order to practice medicine in Florida a physician must be licensed by the Florida Board of Medicine or the Florida Board of Osteopathic Medicine. Licensure requires the following: (1) graduation from a Liaison Committee on Medical Education accredited U.S. medical college or comparable international institution, or an AOA accredited osteopathic medical school (2) receipt of the M.D. or D.O. degree or one of comparable status, (3) completion of at least one year of graduate medical education in an Accreditation Council for Graduate Medical Education (ACGME) approved residency program, or one year internship in an AOA approved program and (4) passage of the U.S. Medical Licensing Examination or the Comprehensive Osteopathic Medical Licensing Examination. Once licensed, physicians may legally practice any medical specialty, whether or not they have completed a residency program in that specialty. "Board Certified" physicians have completed an ACGME residency program in a specialty and passed American Board of Medical Specialties certification examination. Due to stipulations associated with hospital privileges and third-party reimbursement, virtually all physicians are Board Certified.

Residency programs are sponsored by various medical-related institutions including private hospitals, universities, the Veterans Administration (VA) and other healthcare providers. All residency programs must be accredited by the ACGME. Funding is complex, with about 40% of total GME funding coming

from the Medicare program. Medicare is the largest financial supporter of graduate medical education, spending an estimated $9 billion in 2008. Other funding sources include hospitals and the VA.

Residency Programs Nationally

Nationally, there are a total of 8,724 residency programs in 33 specialty and 97 sub-specialty areas, and a total of 110,713 filled residency positions. Specialties and sub-specialties range in numbers of programs from the 458 programs in family medicine to a single program in undersea and hyperbaric medicine. Similarly, specialties range in numbers of filled positions from the 22,702 internal medicine residents to the single resident in congenital cardiac surgery.

The National Residency Matching Program

In any given year, largely through residency completion, a portion of these positions will become vacant and, therefore, available to receive new residents. For the vast majority of these positions, pairing program positions to desirable applicants and, conversely, applicants to suitable residencies is a function of the National Residency Matching Program (NRMP), a private, not-for-profit corporation established in 1952 to optimize the rank-order choices of applicants and residency program directors. Because the NRMP takes place yearly, deals only with that subset of residency programs with vacancies, and produces reliable data over time, it is beneficial data to use in analyzing the status of residency programs. Following the matching process there occurs what is termed *"The Scramble"* associated with remaining unfilled positions and applicants who did not initially match. This much smaller number is not taken into account in the analysis below.

This report also does not take into account the separate matching program that exclusively involves Doctors of Osteopathic medicine.

The 2009 NRMP

On the supply side, in 2009 a total of 25,185 residency positions were offered nationally, 1,000 more than the number offered in 2004. These positions constitute about 23% of all residency slots in existence.

On the demand side, there were 29,888 NRMP active applicants competing for those 25,185 positions. Almost half (15,638) of the applicants were recent U.S. allopathic medical school graduates. Of these, 93% were matched to positions, and of all available positions, 66% were filled by this group. These numbers reflect the desirability by program directors for U.S. allopathic medical school

graduates. U.S. senior match rates have held steady over time; in fact, for the last 27 years U.S. senior match rates have always fallen within a range of 92%-94%.

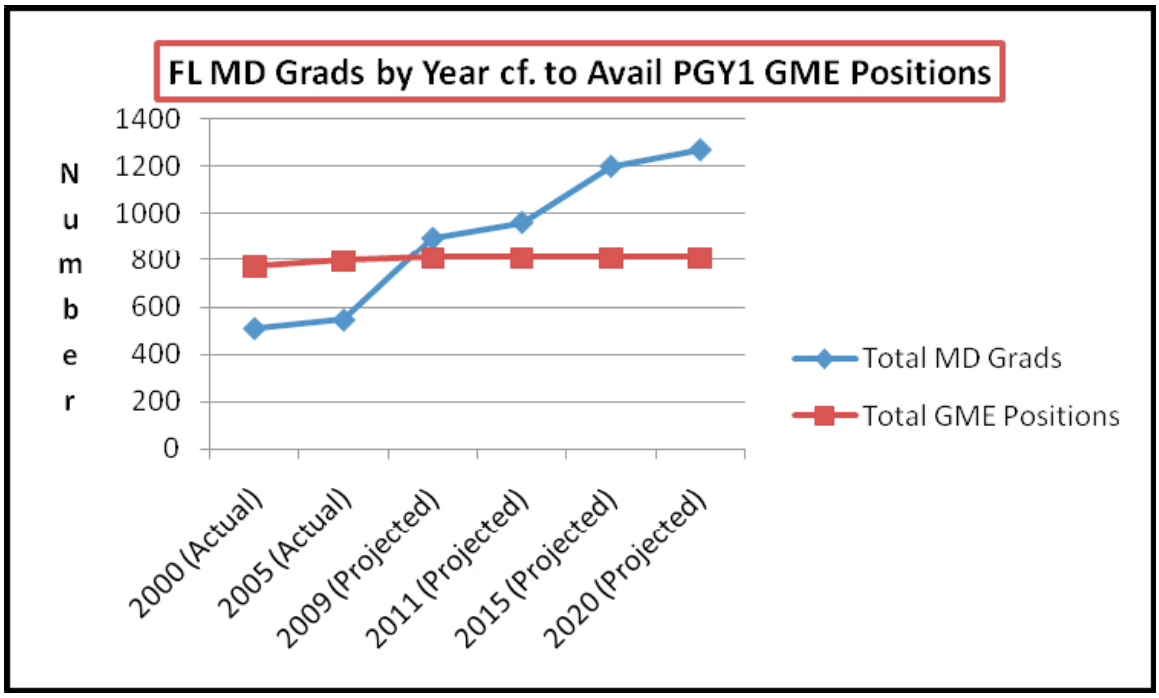
The other approximate half (14,250) of NRMP active applicants was comprised of previous allopathic medical school graduates, osteopathic medical school graduates, graduates of Canadian medical schools, Fifth Pathway students, U.S. citizen graduates of international medical schools, and non-U.S. citizen graduates of international medical schools. In combination, these groups matched only 47% of their applicants to ACGME accredited positions. They are, therefore, virtually half as likely to be matched in the NRMP as are U.S. allopathic graduates. Their strength and value to healthcare provision, however, is in matching with residency positions in specialty areas that are chosen less often by US seniors, such as family medicine.

2009 NRMP Applicants and Matches

Applicants	#	# Matched	% Matched
U.S. Allopathic Seniors	15,568	14,566	93%
Previous U.S. Allopathic Grads	1,222	545	45%
Osteopathic Grads	2,013	1,408	70%
Canadian Med School Grads	35	25	71%
Fifth Pathway	106	65	61%
U.S. Citizen, International Med School	3,390	1,619	48%
Non-U.S. Citizen, "	7,484	3,112	42%
All Applicants	29,888	21,340	71%

In most specialties there continue to be more available positions than U.S. seniors who rank them. Total applicant growth, however, has outpaced position growth, a trend that, absent an increase in the number of residency positions, will surely continue due to the expansion of existing medical schools and the creation of new ones. In 1980 there were 1.19 positions per active NRMP applicant; in 2009 that number had dwindled to .75 positions per active applicant. Without more residency positions the most likely immediate outcome of medical school creation and expansion will be more U.S. allopathic seniors in residency positions (at the same match rate) and fewer internationally trained residents, with no net gain of practising physicians.

Florida, however, is about to "cross the line" by having more medical school graduates than the State's number of GME positions.



U.S. allopathic seniors fill up positions in starkly different patterns according to specialty. For example, they filled 85% of the anesthesiology positions and 88% of the plastic surgery positions but only 46% of the family medicine positions, their #6 highest specialty in matches. By contrast, for each of the categories of prior U.S. allopathic graduates, osteopathic graduates, and both U.S. and non-U.S. citizen graduates of international medical schools, family medicine was the #2 specialty in numbers of matches. Put another way, whereas U.S. seniors comprise 66% of matches in all specialties and subspecialties, they comprise only 46% of family medicine matches. Below are the numbers of matched positions in specialties most often selected by US Seniors, followed by each specialty's percentage of the whole:

2009 NRMP Most Matches

Specialty	# Matched Positions	% of All Matched Positions
Internal Medicine	4,853	22.7%
Pediatrics	2,326	10.9%
Family Medicine	2,311	10.8%
Emergency Medicine	1,459	6.8%
Obstetrics-Gynecology	1,179	5.5%
Surgery	1,060	5%
Psychiatry	1,052	4.9%

Florida Residency Programs

Florida has 238 sponsored residency programs with a total of 2,832 residency positions. With 24 sponsoring institutions, Florida ranks 10th in the U.S. in terms of the number of sponsoring institutions, and 9th in terms of the total number of programs. However, when it comes to numbers of resident positions per 100,000 population, Florida ranks 46th nationally, with residency numbers comparable to North and South Dakota, Nevada, Oklahoma, and Mississippi. The conventional wisdom is that Florida needs another 2,700 residencies.

Florida had 765 residency positions available in the 2009 NRMP. Of these, 740 positions or 97% were matched. (This is a "pre-scramble" number that will have risen subsequent to the scramble activity. These positions are associated with 17 of Florida's 24 sponsoring institutions, including the SUS institutions of Florida State University, the University of Florida, and the University of South Florida. The table below indicates matches in SUS-sponsored programs. The difference between the total quota and the total matched is, in the preponderance of instances, within the subspecialty of surgery-preliminary, and analysis indicates that this is the case in a great many such programs nationally.

SUS NRMP Results

SUS Sponsor	Total Quota	Total Matched
UF COM-Jacksonville	72	70
UF COM-Shands	147	137
FSU COM	10	8
USF COM-Tampa	118	116
	337	323

The table below indicates SUS program specialties and subspecialties, quotas, and totals matched in the 2009 NRMP match. Areas with unmatched quotas are designated in red and by underlining.

UF COM-Jacksonville	Quota	Matched
Emergency Medicine	15	15
Internal Medicine	14	14
Internal Medicine (2)	3	3
Neurology	4	4
Obstetrics-Gynecology	6	6
Orthopaedic Surgery	4	4
Pathology	2	2
Pediatrics	11	11

Radiology-Diagnostic	5	5
General Surgery	4	4
Surgery-Preliminary	4	2
UF COM-Shands Hospital		
Anesthesiology	8	8
Anesthesiology (2)	8	8
Dermatology	2	2
Emergency Medicine	8	8
Family Medicine/SAGH	8	8
Internal Medicine	25	25
Medicine-Preliminary	15	15
Med-Prelim/Neurology	2	2
Neurological Surgery	2	2
Obstetrics-Gynecology	4	4
Orthopaedic Surgery	4	4
Otolaryngology	3	2
Pathology	4	2
Pediatrics	16	16
Psychiatry	6	6
Radiology-Diagnostic	11	11
Radiation Oncology	2	2
General Surgery	5	5
Surgery-Preliminary	8	1
Surg-Prelim/Urology	2	2
FSU-Sacred Heart Hospital-Pensacola		
Obstetrics-Gynecology	3	3
Pediatrics	7	5
USF COM-Tampa		
Dermatology	4	4
Emergency Medicine	10	10
Family Medicine	8	8
Internal Medicine	24	24
Neurological Surgery	2	2
Neurology	4	4
Obstetrics-Gynecology	5	5
Orthopaedic Surgery	4	4
Otolaryngology	2	2
Pathology	4	3
Pediatrics	16	16
PM & R/Spinal Cord Injury	1	0
Phys Medicine & Rehab	2	2
Plastic Surgery	6	6
Psychiatry	8	8

Radiology-Diagnostic	7	7
General Surgery	6	6
Surgery-Preliminary	2	2
Surg-Prelim/Urology	3	3
Vascular Surgery	1	1
Medicine-Pediatrics	5	5

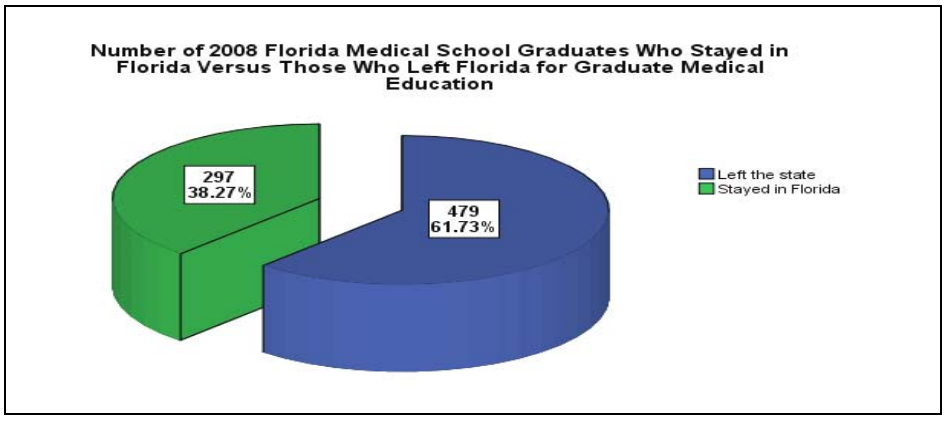
With regard to the total number of residency positions sponsored by SUS institutions, the table below lists the sponsoring institution, the number of approved positions, and the number and percentage of filled positions.

Total SUS Residencies

Sponsoring Institutions	# Approved Positions	# Filled Positions	% Filled Positions
UF COM-Shands	692	641	93%
UF Jacksonville	305	279	91%
USF COM	655	576	88%
FSU COM	33	33	100%
	1,685	1,529	91%

In total, the 1,685 approved positions sponsored by SUS institutions constitutes 59% of Florida's universe of residency positions. On the face of it, Florida residency programs in general and SUS sponsored programs in particular appear to be in high demand and filled at high levels.

There are a total of 156 unfilled SUS residency positions; however, analysis indicates that the preponderance of these vacancies are in years two and three of the residency experience and are, therefore, due to natural and normal attrition associated with change in a professional environment. An issue at hand, however, is the extent to which Florida's medical school graduates stay in Florida for their residency training, as seen in the chart below.

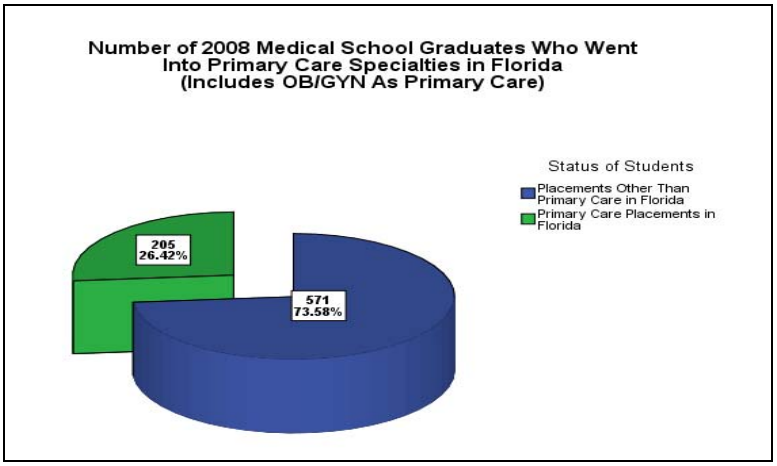


Best Practices and Review

How is it that programs ensure that they are engaging in best/innovative practices? To what extent are SUS and Florida residency positions being filled by Florida's medical school graduates? And what can be determined as to whether SUS programs are in the "right" areas? These questions are relevant given that resident physicians provide approximately 75 percent of Florida's indigent, underinsured and uninsured patient care at an estimated value of close to $1 billion, and given the physician shortage that Florida is facing.

Unlike many Western nations, the United States does not manage or actively regulate the number, type, or geographic distribution of its physician workforce. Recent studies suggest that physician payment disparities and the medical school learning environment are potent factors for specialty choice. Over a 35-40 year career, this payment disparity produces a $3.5 million gap in return on investment between primary care physicians and the midpoint of income for subspecialist physicians. Rural birth, interest in serving underserved or minority populations, all significantly increase the likelihood of students choosing primary care, rural and underserved careers. Being married increases the likelihood of choosing family medicine. Attending a public medical school significantly increases the probability of choosing a primary care specialty and practicing in a rural, shortage or underserved area.

Another potential avenue for identifying "right" residency areas is Florida's Community Hospital Education Program (CHEP), codified in the Community Hospital Education Act (381.0403), is intended to provide a continuing supply of highly trained physicians through graduate medical education. Since the Act is Florida's only self-created funding program for graduate medical education and is intended to reward targeting in specific areas, it is defensible to consider that the GME areas identified there as priorities might at the least serve as proxies, especially until better data is gathered. Those areas identified in the Act are the primary care specialties including family medicine, internal medicine, pediatrics, psychiatry, emergency medicine, obstetrics/gynecology, and combined pediatrics, and internal medicine. The chart below of aggregate data suggests that there are reasons why Florida needs to be considering its mix of programs.



A shorter answer to the question of specialty areas is perhaps that there is with certainty no "right" area with regard to a residency program, because there are multiple viewpoints from which residency programs are regarded. From the viewpoint of some critics, sponsoring institutions should be chiefly driven in their decision-making by societal needs and documented physician shortages. University of Florida administrators, on the other hand, point out that the medical school should continue to do what it does best: nationally recognized programs in specialty areas. In reality, sponsoring institutions are influenced by the factors of specialty shortages at given points in time, by the institutional prestige achieved by virtue of offering certain residency experiences, by the expertise or absence thereof gathered at a particular institution, by funding availability and current federal restrictions on funding new residencies, and, ultimately, by the sponsoring institution's bottom line of profit: a tightrope across which it must traverse while balancing best medical teaching with best medical practice--all beneath a slackening safety net of affordability.

Nevertheless, the question was put to SUS sponsoring institutions, per the Board of Governors Medical Education Resolution referenced at the beginning of this report: to what extent are they periodically reviewing their residency programs and making adjustments to ensure that residency positions are in specialties that meet the needs of the population?

At the University of Florida each program is reviewed extensively on at least a 5 year cycle with regard to the program's effectiveness in meeting ACGME outcomes. In addition, every year each program is required to justify the size of the resident complement in each specialty and the salient trends in practice that bear on the training programs. Any increase in resident complement must be justified, and that justification includes an analysis of the community's need for additional physicians in the specialty being reviewed. All requests for new

training programs undergo a process to demonstrate that the new program is needed, that there is sufficient applicant base, and that the resources are present to provide quality training.

UF interprets innovation to include a pattern of systems-based competencies with attention to safety and quality and the use of information technology. At a more delineated level, this means knowing how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources; practicing cost-effective health care and resource allocation that do not compromise quality of care; advocating for quality patient care and assisting patients in dealing with system complexities; and partnering with health care managers and health care providers to assess and coordinate care.

Even more specific examples of system-based competencies at UF include:

- Residents care for individuals from a diverse socioeconomic background and learn about the constraints various payment schemes put on care.
- Many residents rotate at the Veterans Administration Hospital where they are exposed to the Nation's best electronic medical record. They learn how such a system can improve care by providing alerts and decision support tools.
- Programs receive frequent score cards describing how well they meet core measures in heart failure and pneumonia. In this way, residents learn to practice in an environment where protocols must be followed and physicians are held accountable for results.
- Residents in all programs are required to participate in a quality improvement project during their training, and in some programs new projects are required yearly.
- Residents practice in teams that include discharge planners, social workers, case managers and non-physician extenders. From this, they learn the various roles these other individuals play in the system. The Internal Medicine program has formalized this team in a concept they call "GatorRounds".
- Residents are frequently called on to demonstrate their knowledge promoting life-long learning.
- Some programs require home visits or nursing home visits as part of the curriculum to help residents understand the social contexts their patients live in.

The University of South Florida evaluates its resident complement on a regular basis, at least annually. All existing and new positions are reviewed to assure that they are realistic, contribute to the needs of the region and state, and are of the highest quality. USF believes that its program distribution is comparable to

other major academic institutions in the state and in the region, and reflects the interests of graduating medical students as well as of the population.

Florida State University sponsors only two residency programs at this time. Beginning its 9th year of existence, the college is just starting to focus on growth of GME programs. Without federal funding, it has to rely on partner hospitals to promote the development of residency programs. However, as with all ACGME-accredited training programs, FSU reviews its resident complement annually via its Graduate Medical Education Committee. The programs are also reviewed regularly to ensure that they meet the six ACGME competencies and other requirements for continued accreditation.

While the Association of American Medical Colleges (AAMC) and ACGME both advocate for what, in the general lexicon of higher education, is termed "innovation, best practices, and continuous program improvement", as might be expected, there are specific approvals required to create innovative educational models. The ACGME's Committee on Innovation is charged with a range of efforts to foster high-quality learning and patient care in the settings where residents learn and practice. The Committee focuses on five areas to help create innovation in patient care and education, including integrating care delivery and clinical education and broadening input into redesign of the learning environment through collaboration.

USF has introduced patient safety into all of its residency programs, and the University put in place new courses for medical students and residents last year in patient safety and human error as well as an introductory course in health systems engineering. Furthermore, all programs now have simulation available for initial and advanced training. All program directors have been trained in modern adult educational models, and all programs are now competency-based.

More and Enhanced Residencies

The Council on Graduate Medical Education was authorized by Congress in 1986 to provide an ongoing assessment of physician workforce trends, training issues, and financing policies and to recommend appropriate Federal and private-sector efforts to address identified needs. It was the Council's sixteenth report in 2005 that outlined a significant gap between the expected physician supply and the need for physicians.

The Council's current report, its 19th, starts from the premise that, if the overarching goal is to adequately address the healthcare needs of the nation, then the number of residency positions needs to be expanded, and residency

programs need to improve in what they deliver. The Council has recommended an increase in funded GME positions by a minimum of 15%, with priority given to innovative training models which address community needs and which reflect emerging, evolving, and contemporary models of healthcare delivery.

In addition, the Council recommends that mechanisms should be developed by which local, regional or national groups can determine workforce needs, assign accountability, allocate funding, and develop innovative models of training which meet the needs of the community and of resident physicians. In this regard, Florida has placed itself on the cutting edge with legislation in 2007 creating the Physician Workforce Assessment and Development Act (381.4018, F.S.) which tasks the Florida Department of Health to serve as a coordinating and strategic planning body to actively assess the state's physician workforce needs. The Department has begun this process by creating an Ad Hoc Committee on Physician Workforce (on which the author of this report serves) which, as an initial task, substantially revised and went paperless with the Department's survey administered to all practicing physicians. The importance of this reliable and recent data is obvious: it was not until 2008 that Florida knew that only 67% (37,860 out of 56,197) of its licensed physicians were actively practicing, or that 97% of those practicing were doing so in urban areas.
On the basis of a projected physician shortage, the AAMC called for a 30% increase in enrollment in accredited medical schools over the next ten years. Accordingly, U.S. medical schools are increasing their enrollments, and new medical schools are being established. However, little expansion is planned for GME positions.

In 1997, the Balanced Budget Act froze the number of residents for which a hospital could claim Medicare payment based on the number of residents the hospital trained in 1996. Those residencies not supported by Medicare funding are supported by alternate funding sources that vary by institution and state and are often subject to the vagaries of annual appropriations (which well describes Florida's CHEP).

Medicare caps do not account for changes in demand, including population growth and aging. This antiquated formula has hindered medical schools and teaching hospitals—including those of the SUS—from expanding residency programs and retaining higher numbers of qualified medical students in states where they are most needed.

Numerous calls for reform of and innovation in GME have not been implemented due to these funding restrictions and resistance to change and tension between the provision of services and the educational goals of training programs. Unfortunately, current models of GME financing often prevent the

funding of innovative training models. The gap in funding has widened the chasm between current models of training and future models of healthcare delivery--innovative residency programs featuring interdisciplinary care, across all settings including the physician's office, hospital outpatient and inpatient services, nursing home, home, and community-based care. Unfortunately, the current mechanisms for funding GME are largely disconnected from educational and professional ideals, and remain predominantly hospital-based and tied to delivery of inpatient patient-care services, thus assisting the hospital's bottom line, which has been historically dependent on resident service.

New legislation (see Appendix) has been introduced in Congress to increase the number of Medicare-supported residency training slots. In May 2009, Senators Bill Nelson (D-FL), Harry Reid (D-NV) and Charles Schumer (D-NY) introduced S. 973, The Resident Physician Shortage Reduction Act of 2009, with an identical companion bill, H.R. 2251, introduced in the House by Rep. Kendrick Meek (D-FL), Rep. Kathy Castor (D-FL), and Rep. Joe Crowley (D-NY). Congressman Young and Congresswoman Ros-Lehtinen have also agreed to cosponsor the residency caps legislation.

The Resident Physician Shortage Reduction Act of 2009 would expand the number of Medicare-supported physician residency training positions by 15 percent, or roughly 15,000, with preferences toward primary care education and training in community health centers and other community-based, non-hospital settings. In addition, this legislation would allow residency slots in closed hospitals to be used by nearby teaching hospitals so that these slots are not lost upon closure, as is currently the case.

According to the AAMC, if 1,000 new entry positions were to be added to currently capped teaching hospitals, one would need to pay for 3,960 slots. This assumption is based on all residents undergoing three years of training (3,000), 60 percent of those 1,000 (600) taking four years, and 60 percent of the 600 (360) taking five years. With a recommendation of expanding by 15,000 positions, and given that residency positions cost in the neighborhood of $120-$150K per year, it becomes apparent that the Resident Physician Reduction Shortage Act represents a major investment. The estimated cost for expanding residencies is $156 million over three years.

Conclusion

It is too soon to know the fate of either the Resident Physician Shortage Reduction Act of 2009 or of the even more comprehensive health care reform that is scheduled to be on President Obama's desk by October 2009. Possibly, elements of the former will be subsumed within the latter. Lawmakers are only

beginning to wrestle with specific details, including how to pay for the health care system's massive overhaul. It is encouraging that support seems to be building for some form of bonus payments for primary care physicians, expanding the entire medical workforce, removing barriers to training more residents in community settings, and increasing funding for scholarships and loan forgiveness programs.

Notwithstanding that support, Florida cannot expect that the federal government will be able or inclined to fix all of its problems. Closer to home, the Community Hospital Education Program needs to be reviewed for funding levels, accountability, and efficiency. Existing SUS sponsoring institutions need to continue to review residency programs and to explore expansion. And it goes without saying that the two newest medical schools in the SUS will need to be aggressive and creative when it comes to ensuring new residency positions for their graduates because, without those residency positions, the likelihood is great that Florida's bold investment in medical education will not maximize its returns.

Recommendations

1. Florida needs a multi-agency state and federal strategy to increase residency positions. With the advent of the American Recovery and Reinvestment Act, pending legislation specific to residency expansion, and other legislation regarding health care overhaul, there is simply too much happening too quickly for Florida to wait. A strategy should be developed and then coordinated, identifying potential actions by the Board of Governors, the Department of Health, the Agency for Health Care Administration, the Department of Veterans Affairs, the Office of the Governor, and the Florida Legislature. The strategy should focus on these four separate but connected areas:
    a. increasing residency positions
    b. improving the quality of Florida's residency programs
    c. providing incentives for Floridians to fill Florida's residency positions
    d. providing incentives for residency positions in critical specialties

2. The medical schools at UCF and FIU need to report out on their progress in establishing new residencies.
   UCF and FIU will only open their doors in Fall 2009; therefore, it is premature and may even be deleterious to begin public discussions of residency program establishment. However, it will not be long thereafter that those residency programs will come into play as agents for keeping more Florida trained physicians in Florida, or for luring the best and the brightest from other states to Florida. At an appropriate juncture, the universities need to report on their success at establishing relationships with existing sponsoring institutions and, in the event that more progress needs to be made, collaboration with the UCF and FIU medical schools in meaningful ways needs to become a part of the State's overall GME strategy.

3. Further research needs to be done on physician workforce and existing Florida residency programs. More information is needed regarding Florida's future needs. This research needs to be conducted in conjunction with the Department of Health's Physician Workforce data acquisition improvement. For example, the Department has unmined data as to where all Florida residents went to medical school. Similarly, all SUS schools are generally aware of where their graduates are going for residencies, and this information needs to be analyzed.

   More information could be gathered regarding the extent to which financial reward (for example, $176K a year on average for post-resident

family medicine physicians vs. $450K on average in some other specialty areas) plays a role in specialty selection and is of relevance to the "If we build the family medicine residencies, will they come?" question. This could include a survey of all Florida medical school seniors.

Time restrictions prevented this report from addressing the above areas.

4. The Community Hospital Education Program needs to be reviewed. Florida's only program dedicated to GME funding, the CHEP program has seen the fiscal ebb and flow of legislative funding. More importantly, what was at one time a transparent flow of CHEP funding to GME programs has become more opaque due to the comingling of those funds with others for purposes of being able to draw down greater numbers of federal dollars. The price at the other end has been a loss of transparency and accountability for the dollars intended for GME program destinations. Stakeholders would benefit from reviewing whether current policies and procedures are providing the best return on investment given Florida's healthcare challenges.

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Appendix I

The Resident Physician Shortage Reduction Act of 2009: A Summary

Purpose

This bill will enhance America's health care infrastructure by expanding the number of Medicare-supported physician residency training positions by 15%, or roughly 15,000. In 1997, the Balanced Budget Act froze the number of residents that a hospital could claim Medicare payment for, based on the number of residents that each hospital trained in 1996. Between 1980 and 2005, the nation's population grew by 70 million people—a 31 percent increase. By 2030, as baby boomers age, the number of Americans overage 65 will double from 35 million to 71 million. These changes will significantly increase the demand for physicians' services. In 2007, the Council on Graduate Medical Education recommended increasing Medicare-funded residency positions by at least 15% to meet growing demand. In light of efforts to greatly expand health coverage as part of health reform efforts, this need is even more acute. This legislation would meet that need by expanding Medicare-supported residency slots with preferences for primary care training in community health centers, and other community-based training. It would also make changes to current rules that limit a hospital's flexibility in training its residents in non-hospital settings. Finally, it would allow residency slots in hospitals that close to be used by nearby teaching hospitals so that these slots were not lost upon a hospital closure, as currently is the case.

Section-by-Section Summary

Section 1. Short Title. "Resident Physician Shortage Reduction Act of 2009"

Section 2. Distribution of Additional Residency Positions. The Secretary of Health and Human Services will reduce the resident cap at hospitals by the number of slots that have remained unused over the past five year period. The Secretary will then distribute a number of additional slots equal to 15% of the current number of residency slots in the U.S. Two-thirds of these slots will be given to hospitals that apply for slots for new or expanded residency programs. Preference will be given to hospitals that apply for primary care or general surgery slots, or slots that emphasize community-based training; further preference will be given to hospitals in states with fewer Medicare-sponsored residency slots than medical students, and to hospitals in States with low resident-to-population ratios. The remaining one-third of slots will be allocated proportionately to hospitals operating over their caps, so long as they are training at least 25% of their residents in primary care or general surgery.

Section 3. Counting Resident Time in Outpatient Settings. Currently, the time residents spend training in non-hospital settings can be counted as long as the hospital pays "all or substantially all" of the training costs at that site and the resident spends his or her time in patient care activities. This section would clarify the meaning of "all or substantially all" to allow for the counting of patient care activities as long as the hospital continues to incur the costs of the stipends and fringe benefits of the resident during the time the resident spends training in the non-hospital setting.

Section 4. Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities. The Medicare program currently does not reimburse teaching hospitals with direct GME payments for the time residency trainees spend in educational activities in nonhospital settings. Futhermore, Medicare is not permitted to reimburse teaching hospitals with indirect medical education (IME) payments for the time residency trainees spend in these educational activities in any setting. This section would permit Medicare indirect GME reimbursement for educational activities that occur in the hospital as well as Medicare direct GME reimbursement for educational activities that occur in clinical nonhospital settings (including CHCs and other community-based ambulatory care sites).

Section 5. Preservation of Resident Cap Positions from Closed and Acquired Hospitals. The closure of teaching hospitals significantly impacts the communities served by those hospitals. When a teaching hospital closes, the ability of any entity to obtain Medicare reimbursement on a long-term or permanent basis for the residency slots at the closed hospital ends. This section would allow other providers to receive Medicare payment for same number of residents as were previously reimbursed at the closed facility. When a facility closes, its residency slots would be preferentially allocated to other hospitals in the same geographic area, or to providers outside of the impacted geographic area only if there is not sufficient interest or need for the slots in the same geographic area as the closed hospital. Similarly, when a teaching hospital in bankruptcy is acquired, the acquiring hospital would be permitted to continue to train resident physicians from the acquired teaching hospital to avoid disruption to the community and the trainees.

Appendix II
SUS Funded Enrollments for the M.D. Degree

SUS Funded Enrollment - MD Programs							
YEAR	UF	USF	FSU	FAU-UM	UCF	FIU	TOTAL
2003-04 Funded	460	401	120	-	-	-	981
2004-05 Funded	472	412	180	-	-	-	1,064
2005-06 Funded	474	422	260	-	-	-	1,156
2006-07 Funded	511	480	321	-	-	-	1,312
2007-08 Funded	513	480	360	66	-	-	1,419
2008-09 Funded	538	480	420	80	-	-	1,518
2009-10 Funded	540	480	464	128	40	40	1,692
2010-11 *Projected*	540	480	480	176	100	80	1,856
2011-12 *Projected*	540	560	480	200	180	160	2,120
2012-13 *Projected*	565	640	480	216	280	280	2,461
2013-14 *Projected*	590	720	480	232	360	360	2,742
2014-15 *Projected*	615	800	480	248	420	440	3,003
2015-16 *Projected*	640	800	480	256	460	480	3,116
2016-17 *Projected*	640	800	480	256	480	480	3,136

Note: FAU's ability to increase our total enrollment is contingent upon our ability to access tuition revenue to support the regional campus.